PATIENT HISTORY QUESTIONNAIRE

NAME:_____ AGE_____ TODAYS DATE:_____

ARE YOU RIGHT OR LEFT HANDED:_____ OCCUPATION:_____

REASON FOR VISIT:_____

_____

WHAT HURTS:_____ DURATION (how long this has been going on)_____ _____

PAIN LEVEL: 1-10_____(1 is the least pain, 10 is the worst pain)

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other_____
(circle all that apply)

Do you get any of the following: (circle all that apply)

Numbness Tingling Weakness Night Pain Clicking Stiffness
Popping Instability Loss of Range of Motion Swelling Catching

Pain with: Squatting Weight Bearing Activities At Rest Climbing Stairs
Overhead Activities Throwing Lifting Carrying Reaching

Other Symptoms:_____

What treatments have you had for this problem: X-ray's MRI Physical Therapy Ice Heat
(circle all that apply)
Medications Injections Surgery Other_____

PAST HISTORY
Medical History: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Sleep Apnea	Yes	No
Latex Allergy	Yes	No	Thyroid problems	Yes	No	Other _____		

CURRENT MEDICATIONS (dose and how many times per day)

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES: _____

PAST SURGERIES/HOSPITALIZATIONS AND APPROXIMATE DATES:

_____

_____

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother:_____ Father:_____ Siblings:_____

SOCIAL HISTORY: Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Tobacco Use: ☐ Never ☐ Currently Smoke, how may per day_____ ☐ Quit/ when_____
Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily (how much)_____
Drug Use: ☐ Never ☐ Type and Frequency_____

Please Turn Over

PATIENT HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS: (PLEASE CIRCLE YES OR NO)

CONSTITUTIONAL

Good General Health	YES	NO
Recent Weight Change	YES	NO
Night Sweats/Fevers	YES	NO
Fatigue	YES	NO

CARDIOVASCULAR

Chest Pain	YES	NO
Palpitations	YES	NO
Heart Trouble	YES	NO
Swelling Hands/Feet	YES	NO

MUSCULOSKELETAL

Muscle Pain/Cramps	YES	NO
Stiffness/Swelling Joints	YES	NO
Joint Pain	YES	NO
Trouble Walking	YES	NO

ENDOCRINE

Excessive Thirst/Urination	YES	NO
Thyroid Disease	YES	NO
Hormone Problems	YES	NO

GENITO-URINARY

Blood In Urine	YES	NO
Kidney Stones	YES	NO
Difficulty Urinating	YES	NO
Incontinence Problems	YES	NO

GASTRO-INTESTINAL

Nausea/Vomiting	YES	NO
Abdominal Pain	YES	NO
Rectal Bleeding	YES	NO
Bowel Problems	YES	NO

ALLERGIES

Food Allergies	YES	NO
Drug Allergies	YES	NO

Please List: _____

_____

EARS/NOSE/THROAT/MOUTH

Hearing Loss/Ringing	YES	NO
Sinus Problems	YES	NO
Nose Bleeds	YES	NO
Sore Throat/Voice Change	YES	NO

RESPIRATORY

Shortness Of Breath	YES	NO
Cough	YES	NO
Wheezing/Asthma	YES	NO
Coughing Up Blood		

NEUROLOGICAL

Frequent Headaches	YES	NO
Paralysis or Tremors	YES	NO
Convulsions/Tremors	YES	NO
Numbness/Tingling	YES	NO

HEMATOLOGIC/LYMPHATIC

Bruise Easily	YES	NO
Slow To Heal	YES	NO
Enlarged Glands	YES	NO

EYES

Wear Glasses/Contacts	YES	NO
Eye Disease/Injury	YES	NO
Glaucoma	YES	NO

INTEGUMENTARY (SKIN)

Change In Hair Or Nails	YES	NO
Rashes Or Itching	YES	NO

PSYCHIATRIC

Insomnia	YES	NO
Confusion/Memory Loss	YES	NO
Depression	*YES*	*NO*

PATIENT STATEMENT: To The Best Of My Knowledge The Above Information Is Complete And Accurate.

Signed: _____ Date: _____